Pharmacy Provider Agreement

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Prescription Drug Program. As an enrolled provider in the Indiana Prescription Drug Program, the undersigned entity agrees to provide covered prescription drugs to Indiana Prescription Drug Program members. As a condition of enrollment, Provider agrees to the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("IFSSA").
2. To comply with all applicable statutes and regulations pertaining to the Indiana Prescription Drug Program, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Prescription Drug Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify IFSSA or its agent within ten days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To provide covered prescription drugs for Indiana Prescription Drug Program members pursuant to all applicable statutes and regulations.
6. To safeguard information about Indiana Prescription Drug Program members including at a minimum:
   - *a. members' name, address, and social and economic circumstances;*
   - *b. medical services provided to members;*
   - *c. members' medical data, including diagnosis and past history of disease or disability;*
   - *d. any information received for verifying members' eligibility and amount of assistance payments;*
   - *e. any information received in connection with the identification of legally liable third party resources.*
7. To release information about Indiana Prescription Drug Program members only to the IFSSA or its agent and only when in connection with:
   - *a. providing services for members; and*
   - *b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Indiana Prescription Drug Program - covered prescription drugs.*
8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.

9. To submit claims for services rendered by the provider or employees of the provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide Indiana Prescription Drug Program - covered prescription drugs rendered pursuant to this Agreement.

10. To abide by the Indiana Prescription Drug Program Provider Manual as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its agent.

11. To submit timely billing on Indiana Prescription Drug Program approved claim forms, as outlined in the Indiana Prescription Drug Program Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

12. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

13. To submit claim(s) for Indiana Prescription Drug Program reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.

14. To submit claims that can be documented by Provider as being strictly for:
- *a. medically necessary prescription drugs;*
- *b. prescription drugs actually provided to the person in whose name the claim is being made; and*
- *c. compensation that Provider is legally entitled to receive.*

15. To accept payment as payment in full, as set out in Exhibit C to this Pharmacy Provider Agreement, in accordance with applicable statutes and regulations as the appropriate payment for Indiana Prescription Drug Program benefits provided to Indiana Prescription Drug Program members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Indiana Prescription Drug Program benefits, excluding any co-payment permitted by law. Payment will be made by IFSSA to provider through its Agent no later than 30 days from the close of each billing cycle.

16. To refund within 15 days of receipt, to IFSSA or its agent any duplicate or erroneous payment received.

17. To make repayments to IFSSA or its agent, or arrange to have future payments from the Indiana Prescription Drug Program benefits withheld, within 60 days of receipt of notice from IFSSA or its agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. A hospital licensed under *IC 16-21* has 180 days to repay.

18. To pay interest on overpayments in accordance with applicable law.

19. To make full reimbursement to IFSSA or its agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Indiana Prescription Drug Program.

20. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

21. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Indiana Prescription Drug Program payments made to Provider, to assure the proper administration of the Indiana Prescription Drug Program, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in the Indiana Prescription Drug Program Provider Manual, and shall include, without being limited to, the following:
- *a. medical records;*
- *b. records of all drugs for which vendor payments have been made, including the authority for and the date of administration of such drugs;*
- *c. any records determined by IFSSA or its representative to be necessary to fully disclose and document the extent of benefits provided to individuals receiving assistance under the provisions of the Indiana Prescription Drug Program;*
- *d. documentation in each patient's record that will enable the IFSSA or its agent to verify that each charge is due and proper;*
- *e. financial records maintained in the standard, specified form;*
- *f. all other records as may be found necessary by the IFSSA or its agent in determining compliance with any applicable law, rule, or.*

22. To cease any conduct that IFSSA or its representative deems to be abusive of the Indiana Prescription Drug Program.

23. To promptly correct deficiencies in Provider's operations upon request by IFSSA or its agent.

24. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
- *a. the petitioner is a person to whom the order is specifically directed;*
- *b. the petitioner is aggrieved or adversely affected by the order;*
- *c. the petitioner is entitled to review under the law.*

25. Provider must file a statement of issues within the time limits listed below, setting out in detail:
- *a. the specific findings, actions, or determinations of IFSSA from which Provider is appealing;*
- *b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.*

26. Time limits for filing an appeal and the statement of issues are as follows:
- *a. A hospital licensed under* IC16-21 *must file an appeal of any of the following actions within 180 days of receipt of IFSSA's determination that an overpayment has occurred. The statement of issues must be filed with the request for appeal.*
- *b. Other providers must file an appeal of determination that an overpayment has occurred within 60 days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.*
- *c. All appeals of actions not described in (a) or (b) must be filed within 15 days of receipt of IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.*

27. To cooperate with IFSSA or its agent in the application of utilization controls as provided in applicable statutes and regulations as they may be amended from time to time.

28. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a Indiana Prescription Drug Program benefit.

29. To disclose information concerning the ownership and control [as defined in 42 USC 1320a-3(a)(3)] of the provider, significant business transactions between the provider and any wholly owned supplier or any subcontractor, and information concerning persons with an ownership

or control interest in the provider, or an agent or managing employee who has been convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, or its agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to", "mail to", or home office), federal tax identification number(s), or change in the provider's direct or indirect ownership interest or controlling interest. If a provider fails to disclose ownership or control information as required by this paragraph, IFSSA will terminate the provider agreement.

30. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Exhibit A of this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

31. That subject to item 31, this Agreement shall be effective as of the date set out in the provider notification letter.

32. That this Agreement may be terminated as follows:
- *a. By IFSSA or its agent for Provider's breach of any provision of this Agreement as determined by IFSSA; or*
- *b. By IFSSA or its agent, or by Provider, upon 60 days written notice.*

33. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

Provider-Authorized Signature			
The owner or an authorized officer of the business entity must complete this section.			
I certify, under penalty of law, that the information stated in Exhibit A is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for fraud. I hereby authorize the Indiana Family and Social Services Administration to make all necessary verifications concerning me and my pharmacy practice, and further authorize and request each education institution, license board or organization to provide all information that may be sought in connection with my application for participation in the Indiana Prescription Drug Program.			
Provider DBA Name	_____	Tax ID	_____
Officer Name	_____	Title	_____
Signature	_____	Date	_____
Note: Failure to complete this section will result in agent returning the application for incomplete information.			

EXHIBIT A - *Pharmacy Provider Agreement*

PHARMACY INFORMATION AND CREDENTIALING

Please fill in the following information completely for each pharmacy location.

Corporate Name: _____ Affiliation #: _____

dba/Pharmacy Name: _____

Physical Address: _____

City: _____County: _____ State: _____ Zip:_____

Remittance Address:_____

City: _____ State: _____ Zip:_____

Phone #: (____) _____ Fax #: (____) _____ After Hours #: (____)_____

Pharmacy email address: _____

Federal Tax ID#: _____ Pharmacy DEA#: _____ Renewal Date:_____

State License #: _____ _____ NCPDP#:_____

Professional Liability Insurance Carrier:_____

Policy Limits: $_____ Pharmacist in Charge:_____

Computer Software Vendor: _____ Switch:_____

Store Hours: (M-F) ____ to ____ Sunday ____ to ____
(Sat) ____ to ____ Holidays ____ to ____

Do you provide a separate/private Counseling Area: Yes _____ No _____

Do you provide delivery service? Yes _____ No _____

If Yes, is there a fee and how much? _____

Do you provide compounding? Yes _____ No _____

Do you provide Disease Certification Courses in any of the following areas (check all that apply):

☐ diabetes ☐ coronary disease

☐ asthma ☐ anti-coagulation ☐ Other: _____

Do you have bilingual pharmacists and/or technicians? Yes _____ No _____

If Yes, what languages do they speak? _____

Do you offer special services for the hearing impaired? _____

Do you have staff who know sign language? Yes _____ No _____

How many full time pharmacists do you employ? _____

How many part time pharmacists do you employ? _____

How many technicians currently support the pharmacists?_____

Does your state require technician certification? Yes _____ No _____

EXHIBIT A – PHARMACY INFORMATION AND CREDENTIALING (con't)

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** box**.**

☐ For Profit Corporation ☐ Partnership ☐ Sole Proprietorship

☐ Not-for-Profit Corporation ☐ Government Owned

2. Peer group or locality

Please check the peer group or locality that best describes the service location. Please check **only one** box.

☐ Metropolitan ☐ Rural ☐ Urban ☐ Teaching (Hospitals only)

3**. Is this entity chain affiliated?**

If yes, complete the information in item 5 below.

Yes ☐ No ☐

4. Is this entity operated by a management company, or leased in whole or part by another organization?

If yes, complete the information in item 5 below.

Yes ☐ No ☐

5. List all owners and officers of the business entity

List below the Name, Title, Social Security Number, and Address of each Officer and/or individual who owns five percent or more of the provider entity, and the Name, Tax ID (TIN), and Address of any organization, corporation, or entity having direct or indirect ownership or controlling interest in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	SSN or TIN if organization	Address
Relationship or Title		
Name	SSN or TIN if organization	Address
Relationship or Title		
Name	SSN or TIN if organization	Address
Relationship or Title		

EXHIBIT A – PHARMACY INFORMATION AND CREDENTIALING (con't)

6. Has there been a change in ownership or control within the past year, or is a change of ownership anticipated?

If yes, you must submit the enclosed CHANGE OF OWNERSHIP ADDENDUM form for the current provider entity, and a new application for the new ownership entity.

Yes ☐ No ☐

7. Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

Yes ☐ No ☐ If yes, when? _____

8. Background Information

Has any agent, managing employee, or owner of the provider entity been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs?

Yes ☐ No ☐

If yes, state below the Name, SSN, and position within the provider entity:

_____

_____

_____

EXHIBIT B - *Pharmacy Provider Agreement*

Certification Statement for Providers Submitting Claims

This is to certify that any and all information contained on any Indiana Prescription Drug Program billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau). I fully recognize that any billing intermediary, or service bureau that submits billings to the Family and Social Services Administration (FSSA) or its Agent Contractor is acting as my representative and not that of FSSA or its Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of Indiana Prescription Drug Program claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from public funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable law. The provider will hold harmless and indemnify FSSA from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of Indiana Prescription Drug Program billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of FSSA.

I acknowledge that the fees and charges paid to providers for all pharmacy services rendered shall be in accordance with applicable law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of the Indiana Prescription Drug Program, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by either the Indiana Prescription Drug Program, Agent Contractor, or the Rate Setting Contractor.

I further certify that no supplemental charges will be billed to any Indiana Prescription Drug Program member or to the family of any member for any covered service of the Indiana Prescription Drug Program, except for copayment, member's liability payments, and any other member payments as required by law.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the Indiana Prescription Drug Program, and to furnish such information regarding any Indiana Prescription Drug Program payments claimed for providing such services to FSSA or its designee, upon request, for a period not less than three years from the date of service, or any such period FSSA may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by FSSA or its Agent Contractor. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to its Agent Contractor for claims payment, to document the accuracy of the service for which I have billed the Indiana Prescription Drug Program. I agree to submit such records as may be required by FSSA or its designee.

I understand that FSSA or its designees are prepared to provide necessary technical assistance to assist new providers, or to correct technical problems which existing providers may experience. I realize that all communications regarding electronic, telephonic, mechanical, or standard paper submission of claims shall be between the provider in whose name the claim is submitted and FSSA or its Agent Contractor. I further understand that this technical assistance shall consist of:

- Identification of data element requirements
- Identification of record layouts and other electronic specifications
- Identification of systematic problem areas and recommended solutions

I also agree to notify either FSSA or its Agent Contractor of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission as may be required by FSSA or its Agent Contractor.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the even that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

I recognize that any difference of opinion concerning the amount of Indiana Prescription Drug Program payment for any claim must be adjudicated as provided in Indiana Code 4-21.5-3 and regulations of the program. Further I understand that violation of any of the provisions of this Certification Statement shall make the billing privilege established by this document subject to immediate revocation at FSSA's option.

THE UNDERSIGNED HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY DOES HEREBY AGREE TO ALL OF THE STIPULATIONS, CONDITIONS AND TERMS STATED HEREIN.

Provider Name	Title
Provider Signature Date	Provider Number/Service Location

EXHIBIT C - *Pharmacy Provider Agreement*

BENEFIT PLAN DESCRIPTION
HoosierRx Drug Program

This benefit plan description for the ***HoosierRx Senior Prescription Drug Program***, is as follows:

PRODUCT SELECTION (DAW)
The following DAW (Product Selection) codes will be accepted.

DAW 5 = Brand used as Generic - Generic Pricing

CO-PAYMENTS & MAXIMUM BENEFITS

Brand and Generic Copayment: 50% of allowed charge

All Hoosier Rx Members have a sliding Maximum Benefit of up to $1,000.00 annually, depending on the individual's income eligibility. After the Maximum Benefit has been met, a 100% copayment will be applied to claims processed.

COVERED/EXCLUDED DRUGS
As adjudicated on-line.

DISPENSING LIMITS
On-line messages will indicate appropriate dispensing limit information.

CARDMEMBER ID
Unique HoosierRx ID will be indicated on the ID card.

GROUP NUMBERS
As indicated on the HoosierRx Senior ID Card: INSENR1ØØ

CLAIM VERSION*:*

BIN: 61ØØ84
PCN: PBMXPROD
VERS: 3C (3.2C)

EXHIBIT C - *Pharmacy Provider Agreement*

PAYMENT TERMS

***HoosierRx* Prescription Drug Program**

The payment terms and conditions for ***HoosierRx* Prescription Network** are as follows:

BRAND NAME MEDICATIONS:

The lesser of:

The pharmacy's U&C price** or

AWP* less 13.5% + $4.90

GENERIC MEDICATIONS:

The lesser of:

The pharmacy's U&C price** or

AWP* less 20% + $4.90 or

CMS MAC* + $4.90 or

State MAC + $4.90

* Average Wholesale Price (AWP) and CMS MAC pricing information are supplied by First Data Bank and updated in the ACS State Healthcare Prescription Drug Card System (PDCS) weekly.

** U&C pricing will be the pharmacy's lowest cash discount price including any Senior Cash Discounts.

Signature	Name of Pharmacy
Print Name	NCPDP Number of Pharmacy
Title	
Date	